General Assembly

Committee Bill No. 70

January Session, 2007

LCO No. **4222**

04222SB00070INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT ESTABLISHING THE NUTMEG HEALTH PARTNERSHIP INSURANCE PLAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2007*) There is established a Nutmeg Health Partnership Insurance Plan. The plan shall consist of the measures set forth in sections 1 to 5, inclusive, of this act and sections 5-259, 38a-497, 38a-554 and 38a-567 of the general statutes, as amended by this act, for the purpose of making health insurance accessible and affordable for residents of this state.

Sec. 2. (NEW) (*Effective October 1, 2007*) (a) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any individual health insurance policy or certificate which contains the minimum coverages or benefits set forth in section 38a-503c of the general statutes and subsection (c) of section 38a-504 of the general statutes in addition to those required under subsection (c) of section 38a-505 of the general statutes.

(b) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any individual

health insurance policy or certificate which (1) contains the following minimum coverages or benefits set forth in chapter 700c of the general statutes: Subdivision (2) of subsection (b) of section 38a-476 of the general statutes, sections 38a-476b, 38a-483c, 38a-489, 38a-496, 38a-498a, 38a-502, 38a-503b and 38a-503c of the general statutes and subsection (c) of section 38a-504 of the general statutes, in addition to those required under subsection (c) of section 38a-505 of the general statutes, and (2) offers the following minimum coverages or benefits set forth in chapter 700c of the general statutes as options: Section 38a-488a of the general statutes, sections 38a-490 to 38a-490c, inclusive, 38a-491a, 38a-492 to 38a-493, inclusive, 38a-498, 38a-503, 38a-503d and 38a-503e of the general statutes, subsections (a) and (b) of section 38a-504 of the general statutes, sections 38a-504a to 38a-504g, inclusive, and 38a-507 to 38a-509, inclusive, of the general statutes, provided the insurer, at the time of initial issuance and upon renewal, shall offer the options specified in subdivision (2) of this subsection and receive the acceptance or declination of the insured, in writing, which offer shall include a description of the coverages or benefits and the cost associated with each such coverage or benefit.

Sec. 3. (NEW) (*Effective July 1, 2007*) (a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner; and

(2) "Ineligible population" means (A) part-time employees, seasonal employees and independent contractors who are not eligible to participate in a group health insurance policy offered by an employer or in any other group health insurance policy, as determined by the commissioner, and (B) retired employees under the age of sixty-five who are not eligible to participate in a group health insurance policy offered by a former employer or in any other group health insurance policy, as determined by the commissioner.

(b) Notwithstanding the provisions of chapter 700c of the general statutes, the Insurance Commissioner may approve any group health insurance policy or certificate which does not contain all the minimum

coverages or benefits set forth in chapter 700c of the general statutes, provided such policy or certificate is approved only for issue to the ineligible population in this state.

Sec. 4. (NEW) (*Effective July 1, 2007, and applicable to income years commencing on or after January 1, 2007*) There shall be allowed as a credit against the tax imposed pursuant to chapter 208 of the general statutes in any income year on a small employer an amount equal to the amount paid by such small employer for health insurance for its employees in the income year, provided such small employer has provided health insurance for its employees for a period of three consecutive years. Such credit shall be allowed upon the purchase of any special health care plan, as defined in section 38a-564 of the general statutes, small employer health care health plan, as defined in said section 38a-564, high deductible health plan, as that term is used in subsection (f) of section 38a-520 of the general statutes, or any health insurance procured pursuant to section 5-259 of the general statutes. For the purposes of this section, "small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than ten eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual.

Sec. 5. (NEW) (*Effective July 1, 2007, and applicable to income years commencing on or after January 1, 2007*) There shall be allowed as a credit against the tax imposed pursuant to chapter 229 of the general statutes in any income year on a small employer an amount equal to the amount paid by such small employer for health insurance for its employees in the income year, provided such small employer has provided health insurance for its employees for a period of three consecutive years. Such credit shall be allowed upon the purchase of any special health care plan, as defined in section 38a-564 of the

general statutes, small employer health care health plan, as defined in said section 38a-564, high deductible health plan, as that term is used in subsection (f) of section 38a-520 of the general statutes, or any health insurance procured pursuant to section 5-259 of the general statutes. For the purposes of this section, "small employer" means any person, firm, corporation, limited liability company, partnership or association actively engaged in business or self-employed for at least three consecutive months who, on at least fifty per cent of its working days during the preceding twelve months, employed no more than ten eligible employees, the majority of whom were employed within the state of Connecticut. "Small employer" includes a self-employed individual.

Sec. 6. Subsection (i) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(i) The Comptroller may provide for coverage of employees of municipalities, nonprofit corporations, community action agencies and small employers, **[**and**]** uninsured individuals, individuals eligible for a health coverage tax credit, retired members or members of an association for personal care assistants under the plan or plans procured under subsection (a) of this section, provided: (1) Participation by each municipality, nonprofit corporation, community action agency, small employer, uninsured individual, eligible individual, retired member or association for personal care assistants shall be on a voluntary basis; (2) where an employee organization represents employees of a municipality, nonprofit corporation, community action agency or small employer, participation in a plan or plans to be procured under subsection (a) of this section shall be by mutual agreement of the municipality, nonprofit corporation, community action agency or small employer and the employee organization only and neither party may submit the issue of participation to binding arbitration except by mutual agreement if such binding arbitration is available; (3) no group of employees shall

be refused entry into the plan by reason of past or future health care costs or claim experience; (4) rates paid by the state for its employees under subsection (a) of this section are not adversely affected by this subsection; (5) administrative costs to the plan or plans provided under this subsection shall not be paid by the state; (6) participation in the plan or plans in an amount determined by the state shall be for the duration of the period of the plan or plans, or for such other period as mutually agreed by the municipality, nonprofit corporation, community action agency, small employer, uninsured individual, retired member or association for personal care assistants and the Comptroller; and (7) nothing in this section or section 12-202a, 38a-551, 38a-553 or 38a-556 shall be construed as requiring a participating insurer or health care center to issue individual policies to individuals eligible for a health coverage tax credit. The coverage provided under this section may be referred to as the "Municipal Employee Health Insurance Plan". The Comptroller may arrange and procure for the employees, uninsured individuals and eligible individuals under this subsection health benefit plans that vary from the plan or plans procured under subsection (a) of this section. Notwithstanding any provision of part V of chapter 700c, the coverage provided under this subsection may be offered on either a fully underwritten or risk-pooled basis at the discretion of the Comptroller. For the purposes of this subsection, (A) "municipality" means any town, city, borough, school district, taxing district, fire district, district department of health, probate district, housing authority, regional work force development board established under section 31-3k, regional emergency telecommunications center, tourism district established under section 32-302, flood commission or authority established by special act, regional planning agency, transit district formed under chapter 103a, or the Children's Center established by number 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a nonprofit corporation organized under 26 USC 501 that has a contract with the state or receives a portion of its funding from a municipality, the state or the federal government, or (ii) an organization that is tax exempt pursuant

to 26 USC 501(c)(5); (C) "community action agency" means a community action agency, as defined in section 17b-885; (D) "small employer" means a small employer, as defined in subparagraph (A) of subdivision (4) of section 38a-564; (E) "eligible individuals" or "individuals eligible for a health coverage tax credit" means individuals who are eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in accordance with the Pension Benefit Guaranty Corporation and Trade Adjustment Assistance programs of the Trade Act of 2002 (P.L. 107-210); (F) "association for personal care assistants" means an organization composed of personal care attendants who are employed by recipients of service (i) under the home-care program for the elderly under section 17b-342, (ii) under the personal care assistance program under section 17b-605a, (iii) in an independent living center pursuant to sections 17b-613 to 17b-615, inclusive, or (iv) under the program for individuals with acquired brain injury as described in section 17b-260a; **[**and**]** (G) "retired members" means individuals eligible for a retirement benefit from the Connecticut municipal employees' retirement system; and (H) "uninsured individual" means an individual who has no access to employer-sponsored or government-sponsored health insurance and whose adjusted gross income does not exceed fifty thousand dollars.

Sec. 7. Subsection (k) of section 5-259 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(k) The Comptroller shall submit annually to the General Assembly a review of the coverage of employees of municipalities, nonprofit corporations, community action agencies, small employers under subsection (i) of this section and eligible individuals under subsection (i) of this section beginning February 1, 2004, and uninsured individuals beginning February 1, 2008.

Sec. 8. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

[Every**]** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended or renewed in this state on or after October 1, **[**1982**]** 2007, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child marries, ceases to be a dependent of the policyholder **[**,**]** or attains the age of **[**nineteen if the child is not a full-time student at an accredited institution, or attains the age of twenty-three if the child is a full-time student at an accredited institution**]** twenty-three.

Sec. 9. Section 38a-554 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553 and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) dependent unmarried children **[**,**]** who are under the age of **[**nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning**]** twenty-three.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) and (4) of this subsection: (1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a

result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for the periods set forth for such event under federal extension requirements established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA), except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (3) regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child marries, ceases to be dependent on the employee or attains the age of **[**nineteen**]** twenty-three, whichever occurs first. **[**, except that if the child is a full-time student at an accredited

institution, the coverage may be continued while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of twenty-three.**]** If on the date specified for termination of coverage on a dependent child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) as to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this

subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

Sec. 10. Section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Health insurance plans and insurance arrangements covering small employers and insurers and producers marketing such plans and arrangements shall be subject to the following provisions:

(1) (A) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the small employer, policyholder or contractholder, as the case may be, except: (i) For nonpayment of the required premiums by the small employer, policyholder or contractholder; (ii) for fraud or misrepresentation of the small employer, policyholder or contractholder or, with respect to coverage of individual insured, the

insureds or their representatives; (iii) for noncompliance with plan or arrangement provisions; (iv) when the number of insureds covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (v) when the small employer, policyholder or contractholder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(B) Renewability of coverage may be effected by either continuing in effect a plan or arrangement covering a small employer or by substituting upon renewal for the prior plan or arrangement the plan or arrangement then offered by the carrier that most closely corresponds to the prior plan or arrangement and is available to other small employers. Such substitution shall only be made under conditions approved by the commissioner. A carrier may substitute a plan or arrangement as stated above only if the carrier effects the same substitution upon renewal for all small employers previously covered under the particular plan or arrangement, unless otherwise approved by the commissioner. The substitute plan or arrangement shall be subject to the rating restrictions specified in this section on the same basis as if no substitution had occurred, except for an adjustment based on coverage differences.

(C) Notwithstanding the provisions of this subdivision, any such plan or arrangement, or any coverage provided under such plan or arrangement may be rescinded for fraud, material misrepresentation or concealment by an applicant, employee, dependent or small employer.

(D) Any individual who was not a late enrollee at the time of his or her enrollment and whose coverage is subsequently rescinded shall be allowed to reenroll as of a current date in such plan or arrangement subject to any preexisting condition or other provisions applicable to new enrollees without previous coverage. On and after the effective date of such individual's reenrollment, the small employer carrier may

modify the premium rates charged to the small employer for the balance of the current rating period and for future rating periods, to the level determined by the carrier as applicable under the carrier's established rating practices had full, accurate and timely underwriting information been supplied when such individual initially enrolled in the plan. The increase in premium rates allowed by this provision for the balance of the current rating period shall not exceed twenty-five per cent of the small employer's current premium rates. Any such increase for the balance of said current rating period shall not be subject to the rate limitation specified in subdivision (6) of this section. The rate limitation specified in this section shall otherwise be fully applicable for the current and future rating periods. The modification of premium rates allowed by this subdivision shall cease to be permitted for all plans and arrangements on the first rating period commencing on or after July 1, 1995.

(2) Except in the case of a late enrollee who has failed to provide evidence of insurability satisfactory to the insurer, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-2721, as amended) or other applicable laws. The employee or dependent must request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

(3) (A) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, the premium rates charged or offered for a rating period for all plans and arrangements may not exceed one

hundred thirty-five per cent of the base premium rate for all plans or arrangements.

(B) For rating periods commencing on or after July 1, 1994, and prior to July 1, 1995, the premium rates charged or offered for a rating period for all plans or arrangements may not exceed one hundred twenty per cent of the base premium rate for such rating period. The provisions of this subdivision shall not apply to any small employer who employs more than twenty-five eligible employees.

(4) For rating periods commencing on or after October 1, 1993, and prior to July 1, 1995, the percentage increase in the premium rate charged to a small employer, who employs not more than twenty-five eligible employees, for a new rating period may not exceed the sum of:

(A) The percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(B) An adjustment of the small employer's premium rates for the prior rating period, and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer, such adjustment (i) not to exceed ten per cent annually for the rating periods commencing on or after October 1, 1993, and prior to July 1, 1994, and (ii) not to exceed five per cent annually for the rating periods commencing on or after July 1, 1994, and prior to July 1, 1995; and

(C) Any adjustments due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's applicable rate manual.

(5) (A) With respect to plans or arrangements issued on or after July 1, 1995, the premium rates charged or offered to small employers shall be established on the basis of a community rate, adjusted to reflect one or more of the following classifications:

(i) Age, provided age brackets of less than five years shall not be utilized;

(ii) Gender;

(iii) Geographic area, provided an area smaller than a county shall not be utilized;

(iv) Industry, provided the rate factor associated with any industry classification shall not vary from the arithmetic average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average, and provided further, the rate factors associated with any industry shall not be increased by more than five per cent per year;

(v) Group size, provided the highest rate factor associated with group size shall not vary from the lowest rate factor associated with group size by a ratio of greater than 1.25 to 1.0;

(vi) Administrative cost savings resulting from the administration of an association group plan or a plan written pursuant to section 5-259, provided the savings reflect a reduction to the small employer carrier's overall retention that is measurable and specifically realized on items such as marketing, billing or claims paying functions taken on directly by the plan administrator or association, except that such savings may not reflect a reduction realized on commissions;

(vii) Savings resulting from a reduction in the profit of a carrier who writes small business plans or arrangements for an association group plan or a plan written pursuant to section 5-259 provided any loss in overall revenue due to a reduction in profit is not shifted to other small employers; **[**and**]**

(viii) Family composition, provided the small employer carrier shall utilize only one or more of the following billing classifications: (I) Employee; (II) employee plus family; (III) employee and spouse; (IV) employee and child; (V) employee plus one dependent; and (VI)

employee plus two or more dependents; and

(ix) Expected level of participation in a qualified wellness or disease management program offered by a small employer carrier on or after July 1, 2008, that meets the requirements specified in the Health Insurance Portability and Accountability Act of 1996 (P. L. 104-191) (HIPAA), as amended from time to time, for bona fide wellness programs, and the anticipated effect such program will have on utilization or medical claim costs, provided (I) the maximum differential attributed to such rate factor shall not exceed a ratio of 1.25 to 1.0, and (II) the commissioner has approved the program materials and the methodology proposed for establishing such rate factor. Not later than July 1, 2008, the commissioner shall adopt regulations, in accordance with chapter 54, which shall specify additional standards for such program and the factors that the methodology may consider in determining how the rating factor will vary based on the anticipated efficacy of the program in reducing expected utilization or medical claim costs.

(B) The small employer carrier shall quote premium rates to small employers after receipt of all demographic rating classifications of the small employer group. No small employer carrier may inquire regarding health status or claims experience of the small employer or its employees or dependents prior to the quoting of a premium rate.

(C) The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued on or after July 1, 1995. The provisions of subparagraphs (A) and (B) of this subdivision shall apply to plans or arrangements issued prior to July 1, 1995, as of the date of the first rating period commencing on or after that date, but no later than July 1, 1996.

(6) For any small employer plan or arrangement on which the premium rates for employee and dependent coverage or both, vary among employees, such variations shall be based solely on age and other demographic factors permitted under subparagraph (A) of

subdivision (5) of this section and such variations may not be based on health status, claim experience, or duration of coverage of specific enrollees. Except as otherwise provided in subdivision (1) of this section, any adjustment in premium rates charged for a small employer plan or arrangement to reflect changes in case characteristics prior to the end of a rating period shall not include any adjustment to reflect the health status, medical history or medical underwriting classification of any new enrollee for whom coverage begins during the rating period.

(7) For rating periods commencing prior to July 1, 1995, in any case where a small employer carrier utilized industry classification as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetical average of the highest and lowest rate factors associated with all industry classifications by greater than fifteen per cent of such average.

(8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(9) For rating periods commencing prior to July 1, 1995, in any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

(10) If a small employer carrier denies coverage to a small employer, the small employer carrier shall promptly offer the small employer the opportunity to purchase a special health care plan or a small employer health care plan, as appropriate. If a small employer carrier or any

producer representing that carrier fails, for any reason, to offer such coverage as requested by a small employer, that small employer carrier shall promptly offer the small employer an opportunity to purchase a special health care plan or a small employer health care plan, as appropriate.

(11) No small employer carrier or producer shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, except the provisions of this subparagraph shall not apply to information provided by a small employer carrier or producer to a small employer regarding the carrier's established geographic service area or a restricted network provision of a small employer carrier; or

(B) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(12) No small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic area of the small employer. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a special or a small employer health care plan. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(13) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(14) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reasons for the denial.

(15) No small employer carrier or producer shall disclose (A) to a small employer the fact that any or all of the eligible employees of such small employer have been or will be reinsured with the pool, or (B) to any eligible employee or dependent the fact that he has been or will be reinsured with the pool.

(16) If a small employer carrier enters into a contract, agreement or other arrangement with another party to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the other party shall be subject to the provisions of this section.

(17) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers.

(18) Each small employer carrier shall maintain at its principle place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. Each small employer carrier shall file with the commissioner annually, on or before March fifteenth, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods have been derived using recognized actuarial principles consistent with the

provisions of sections 38a-564 to 38a-573, inclusive. Such certification shall be in a form and manner and shall contain such information, as determined by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principle place of business. Any information and documentation described in this subdivision but not subject to the filing requirement shall be made available to the commissioner upon his request. Except in cases of violations of sections 38a-564 to 38a-573, inclusive, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(19) The commissioner may suspend all or any part of this section relating to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(20) For rating periods commencing prior to July 1, 1995, a small employer carrier shall quote premium rates to any small employer within thirty days after receipt by the carrier of such employer's completed application.

(21) Any violation of subdivisions (10) to (16), inclusive, and any regulations established under subdivision (17) of this section shall be an unfair and prohibited practice under sections 38a-815 to 38a-830, inclusive.

(22) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259, <u>as amended by this act,</u> or by an association group plan, at the option of the Comptroller or the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance

shall not be subject to this section, provided (A) the plan or plans offered or issued cover such small employers as a single entity and cover not less than ten thousand eligible individuals on the date issued, (B) each small employer is charged or offered the same premium rate with respect to each eligible individual and dependent, and (C) the plan or plans are written on a guaranteed issue basis.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2007*	New section
Sec. 2	*October 1, 2007*	New section
Sec. 3	*July 1, 2007*	New section
Sec. 4	*July 1, 2007, and applicable to income years commencing on or after January 1, 2007*	New section
Sec. 5	*July 1, 2007, and applicable to income years commencing on or after January 1, 2007*	New section
Sec. 6	*October 1, 2007*	5-259(i)
Sec. 7	*October 1, 2007*	5-259(k)
Sec. 8	*October 1, 2007*	38a-497
Sec. 9	*October 1, 2007*	38a-554
Sec. 10	*July 1, 2007*	38a-567

Statement of Purpose:

To establish the Nutmeg Health Partnership Insurance Plan for the purpose of making health insurance accessible and affordable for residents of this state.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

Co-Sponsors: SEN. CRISCO, 17th Dist.

S.B. 70